

ENROLLMENT FORM



IBA Health and Life Assurance Company

Medical PPO and Traditional Indemnity Insurance Underwritten by IBA
Life Insurance, Dental Insurance Underwritten by IBA

Please type or print (press firmly).

Employee - Complete A, B, C, D, E, F. Employer - Complete G.

A. EMPLOYEE INFORMATION

| | | | | | |
|-------------------|-------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------|------------|-----------|------------------------|
| First Name | M.I. | Last Name | Sex M F | Birthdate | Social Security Number |
| Street Address | Apt. No. | City | State | Zip Code | County |
| Home Phone () | Work Phone () | Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed | | | |

B. COVERAGE ELECTION (CHECK ALL THAT APPLY)

| | | |
|----------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| MEDICAL INSURANCE <input type="checkbox"/> Single Medical <input type="checkbox"/> Family Medical | LIFE INSURANCE (Life coverage is mandatory for groups of under 50 subscribers) If life benefit is included please complete: <input type="checkbox"/> Life/Accidental Death & Dismemberment <input type="checkbox"/> Dependent Life Your beneficiary's Full Name _____ Relationship _____ Beneficiary's Full Address _____ | WAIVER OF COVERAGE (Must be completed if employee and/or dependents waive either medical, dental, or life coverages. Life Coverage may not be waived for groups under 50 subscribers.) <input type="checkbox"/> No Employee Medical Coverage <input type="checkbox"/> No Dependent Medical Coverage <input type="checkbox"/> No Employee Dental Coverage <input type="checkbox"/> No Dependent Dental Coverage <input type="checkbox"/> No Employee Life Coverage <input type="checkbox"/> No Dependent Life Coverage Reason: <input type="checkbox"/> Covered under another plan <input type="checkbox"/> Other: _____ Signature: _____ |
|----------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|

THE COVERAGE ELECTIONS IN THIS SECTION (B) ARE NOT EFFECTIVE UNTIL APPROVED BY THE COMPANY.

C. FAMILY INFORMATION - Use extra paper if necessary.

- List all family members to be covered. Write name as it should appear on I.D. card. All eligible family members will be listed on EACH I.D. card.
- Student status information will be required for all family members which exceed the age stated for dependents in the Master Group Contract or Policy.
- Indicate dependent address (if different) in the space provided below.

| | First Name | M.I. | Last Name | Social Security Number | Relationship | Sex | Birthdate | Full Time College Student |
|----|------------|------|-----------|------------------------|--------------|--------|-----------|---------------------------------------------------------------------------|
| 01 | Address: | | | | SPOUSE | M F | | Yes No |
| 02 | Address: | | | | | M F | | <input type="checkbox"/> Yes <input type="checkbox"/> No College Name: |
| 03 | Address: | | | | | M F | | <input type="checkbox"/> Yes <input type="checkbox"/> No College Name: |
| 04 | Address: | | | | | M F | | <input type="checkbox"/> Yes <input type="checkbox"/> No College Name: |

D. HEALTH INFORMATION - Explain any "YES" answers in complete detail. Use extra paper if necessary.

| | |
|-------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <input type="checkbox"/> Yes <input type="checkbox"/> No | 1. Have you or your dependents visited a health care professional in the last 5 years for any illness, injuries or medical conditions (including mental health and chemical dependency)? If yes, list person's name, dates, and reason for and results of visits. |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | 2. Have you or your dependents had any hospitalizations (including inpatient and outpatient) in the last 5 years? If yes, list person's name, dates and reason hospitalized or treated. |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | 3. Have you or your dependents taken any prescription medications in the last 12 months? (If you are unsure of the medication name, please indicate the condition for which it was prescribed.) If yes, list the person's name, name of drugs and dates taken. |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | 4. Are you or your dependents aware of any condition, illness or injury which may require ongoing or future surgery or treatment of any type, or has any surgery or treatment been recommended that has not yet been performed? |

E. OTHER HEALTH INSURANCE INFORMATION (THIS SECTION MUST BE COMPLETED)

On the day your coverage begins will you or any family members, including those not listed above, be covered by other insurance or Medicare? Yes No

If yes, please complete this section. Use extra paper if more than one additional policy will be in force.

| | | |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------|----------------------------------------------------------------------------------------------------------------|
| Coverage Type: <input type="checkbox"/> Medical Insurance <input type="checkbox"/> Life Insurance <input type="checkbox"/> Medicare (see below) <input type="checkbox"/> Dental Insurance <input type="checkbox"/> STD Insurance | Insurance Company Name and Phone Number | Policy Number |
| Policy Coverage Dates _____ to _____ | Name of Policyholder | Policyholder's Birthdate |
| Family Members Covered | | Phone Number |
| Names of Family Members Covered by Medicare | Medicare Claim Number | Part A Effective Date |
| | | Part B Effective Date |
| | | Is Medicare Eligibility Due to: <input type="checkbox"/> Kidney Failure <input type="checkbox"/> Disability |

F. SIGNATURE

AUTHORIZATION TO OBTAIN OR RELEASE MEDICAL INFORMATION: On behalf of myself and anyone enrolled on or added to this application ("Us"), I authorize any health care professional or entity to give IBA Health and Life Assurance Company, its affiliates, and the employer or any of their designees, any and all records or information pertaining to medical history or services rendered to Us for any administrative purpose, including evaluation of an application or a claim, and for any analytical or research purposes. I also authorize on behalf of Us the use of a Social Security Number for purpose of identification. The information provided on this application is accurate and complete. I understand and agree that any omissions or incorrect statements knowingly made by Us on this application may invalidate my and/or my dependent's coverage.

NOTICE OF ENROLLMENT RIGHTS: I understand that if I decline enrollment for myself or my dependents (including spouse) because of other health coverage, I may in the future be able to enroll myself or my dependents in this plan, provided that I request enrollment within 30 days after such coverage ends. In addition, if a new dependent relationship forms as a result of marriage, birth, adoption, or placement for adoption, I may be able to enroll myself and my dependents provided that I request enrollment within 30 days after such marriage, birth, adoption, or placement for adoption.

X

Employee Signature

Date Signed

G. FOR EMPLOYER USE ONLY

| | | |
|--------------------------------------------------------------------------|-------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|
| Company Name | Branch/Division | Group Number |
| Employee I.D. Number | Hire Date | Effective Date |
| | <input type="checkbox"/> Open Enrollment <input type="checkbox"/> New Hire | <input type="checkbox"/> Status Change _____ (date) <input type="checkbox"/> Return from layoff/leave on _____ (date) |
| <input type="checkbox"/> Full Time <input type="checkbox"/> Part Time | <input type="checkbox"/> Union <input type="checkbox"/> Non-Union | <input type="checkbox"/> Salaried <input type="checkbox"/> Hourly |
| Approved By (Signature) | | Date |

FOR COMPANY USE ONLY

| | | | | | | |
|--------------|-------------------|--------|------------|------------|-----------|---------------|
| Group Number | Effective Date(s) | County | Rate Class | Department | Duplicate | Date Received |
|--------------|-------------------|--------|------------|------------|-----------|---------------|